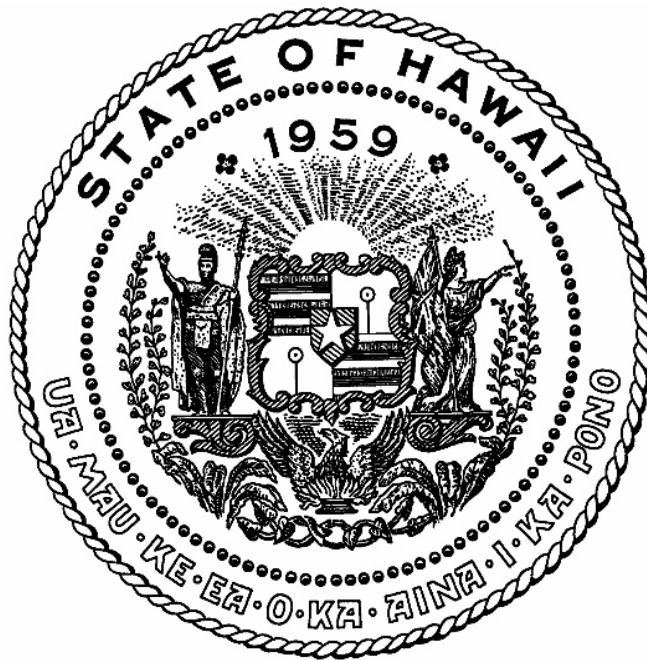


Hawaii Employer-Union Health Benefits Trust Fund

REFERENCE GUIDE (EUTF and HSTA VB)



FOR ACTIVE EMPLOYEE BENEFIT PLANS *Effective July 1, 2013 through June 30, 2014*

Disclaimer: This Reference Guide offers general information on your health and other benefits plans. Your health benefits are exclusively governed by Hawaii Statutes and the EUTF Administrative Rules, as they are amended from time to time. Nothing in this Guide is intended to amend, change, or contradict the Hawaii Statutes and the EUTF Administrative Rules. This Guide is not a legal document or contract and the information in the Guide is not intended as legal advice or to create any legal or contractual liabilities.

Welcome to Open Enrollment for EUTF Active Employee Benefit Plans

The Open Enrollment period for EUTF Active Employee Health and Life insurance plans will be from April 15, 2013 through May 10, 2013.

Why is Open Enrollment special?

Now is the time when you can stop and think about health coverage for yourself and your family and determine which plan offered will best meet your needs. During open enrollment you can:

- Add a plan, change from one plan to another, or drop a plan
- Add a dependent or drop a dependent
- Change coverage tiers such as changing from single to family or family to 2-party
- Now is also a good time to tell us if you've had a change of address

Open enrollment is your only opportunity to make these changes without a qualifying event such as needing to enroll a new dependent due to marriage or a birth. Paperwork must be submitted during the open enrollment period for changes to become effective July 1, 2013. So, now is the time to think about health benefits.

Here are the important dates:

- **Open Enrollment Election Period:** April 15, 2013 through May 10, 2013
- New coverage becomes effective: July 1, 2013
- Rates change effective: July 1, 2013
- Plan Period: July 1, 2013 through June 30, 2014

Here's what you need to do now:

- **Know what you are enrolled in now:** What plans are you enrolled in? Who are the dependents enrolled on your plans?
- **Learn what's being offered:** Read this Reference Guide to learn more about the plans and their cost. Attend an Open Enrollment informational session to get more details and talk to carrier representatives.
- **Make a decision about which plans best suit your needs**
- **Fill out the appropriate form:** Please refer to page 3 for complete enrollment instructions.

IF YOU DON'T WANT TO MAKE ANY CHANGES, DO NOTHING. If you don't fill out a form, your current plan selections and covered dependents will continue into the new plan year. If you are currently enrolled in the HMSA HDHP plan or the Kaiser Basic plan, please refer to page 3.

This guide can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990.

Please contact the EUTF office at 808-586-7390 or toll-free at 1-800-295-0089 for special needs assistance.

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Plan Administrator Changes

EUTF Medical Plans

Effective July 1, 2013 for Actives: The EUTF High Deductible Health Plan (HDHP) – HMSA will be replaced by the EUTF 75/25 PPO Plan – HMSA with CVS Caremark as the administrator for prescription drugs. The EUTF Kaiser Basic HMO Plan will also be replaced by the EUTF Kaiser Standard HMO Plan. If you do nothing during Open Enrollment, you will automatically be enrolled in the plans listed below. You have the option to enroll in a new plan by submitting the Form EC-1.

	What if:	Then:
Current Benefit Plan		Your Plan Effective July 1, 2013
EUTF HDHP – HMSA Medical and HMSA Prescription Drug	I do nothing.	EUTF 75/25 PPO – HMSA Medical and CVS Caremark Prescription Drug
EUTF Kaiser Basic HMO Medical and Prescription Drug	I do nothing.	EUTF Kaiser Standard HMO Medical and Prescription Drug

There are no changes to the HSTA VB plans. HSTA VB refers to plans created for HSTA members who were previously enrolled in the HSTA VEBA plans.

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Open Enrollment Instructions

Step 1: **Review the choices available to you and decide whether you want to change** or keep your plans. If you decide to keep your current benefit plans, do nothing. You are not required to complete any forms to keep your current plans.

Step 2: **Gather Information:** If you have questions about your plan choices, please attend an Open Enrollment Informational Session. The schedule of sessions with location information is on page 9.

During Open Enrollment, all active employees are invited to explore healthcare and insurance options at the informational sessions. The following insurance carriers and administrator representatives will be on hand to answer your questions about their benefit plans.

Medical plans:	HMSA & Kaiser
Prescription Drug plan:	CVS Caremark & Kaiser
Supplemental Medical & Drug Plans:	HMSA & Royal State National
Dental plan:	HDS
Vision plan:	VSP
Life insurance:	Royal State National
Chiropractic plan:	Royal State National

If you are not sure which plan you're enrolled in now, refer to the carrier websites or call the carrier customer service numbers which are on your ID cards. There are also links to carrier websites on the EUTF website eutf.hawaii.gov.

- Step 3: Which Plans do you want to enroll in?** Review this Reference Guide and determine which selection of health plans best meets your needs. The EUTF website includes links to insurance carriers' web pages along with the latest information regarding the open enrollment. Questions regarding specific provisions such as are certain services covered should be directed to the carriers. Please refer to page 59 for contact information. The Summary of Benefits and Coverage for the various plans can be found at EUTF's website at eutf.hawaii.gov.
- Step 4: How much will it cost you?** Review the rates on pages 6-8 which show the total cost. At the time of printing, no new agreements have been reached between the employers and unions in regards to dividing the costs of EUTF benefits. The most current cost sharing information between the employer and employee can be obtained from your union representative or your personnel office.
- Step 5: Who do you need to cover?** You can add or drop dependents to your plan, including a spouse, domestic partner (DP), civil union partner (CUP) or eligible children. Adding a domestic or civil union partner requires additional documentation. Please contact the EUTF to obtain the appropriate forms or go to the EUTF website, eutf.hawaii.gov, to download those forms. Refer to the Employee – Dependent Eligibility section of this Guide for details on who can be enrolled as an eligible dependent.
- Step 6: Complete the Enrollment Form:** **Make your selections on the Form EC-1 for Active Employees, or EC-1H for those eligible for HSTA VB plans. Please refer to pages 50-57 for a copy or these forms can be downloaded from the EUTF website, eutf.hawaii.gov.**

A: To make changes to your personal information, such as your address, complete Section 1 on the Form EC-1 or EC-1H.

B: To change your plans, coverage selection or dependent information, including adding or dropping dependents or updating their data, complete Sections 1, 3, 4, 5 and 6 on the Form EC-1 or EC-1H. **Please mark all the coverages you want to be enrolled in, not just the ones you want to change.**

NOTE: If you are adding a new dependent, you are required to submit your dependent's Social Security number at the initial enrollment (except newborns).

C: Employees who are enrolled in the HSTA VB plans who change to the EUTF plans may NOT change back to HSTA VB plans in the future. Additionally, employees enrolled in the HSTA VB plans may not enroll in some HSTA VB plans and some EUTF plans – they must be enrolled in all HSTA VB plans or all EUTF plans.

NOTE: Fill out all sections of the form, not just the information that is changing.

Step 7: THE MOST IMPORTANT STEP: REVIEW YOUR COMPLETED FORM. Make sure these are the plans you want and the dependents you want to cover are eligible for coverage. You will not be able to change your selections after Open Enrollment ends, unless you experience a qualifying event.

Last Step: Submit the completed and signed form to your identified open enrollment designee no later than May 10, 2013.

The designee may be your office secretary, financial officer, human resources personnel—find out who has been designated by your agency/department. It is very important that you submit your completed form on time.

FORMS SUBMITTED AFTER MAY 10, 2013 WILL BE REJECTED.

The EUTF will send you an enrollment **confirmation notice** after processing is completed. The confirmation notice allows you to ensure that the changes you submitted were entered correctly. If you note an error, notify the EUTF immediately. **However, after May 10, 2013 we can only make changes if there is an error in our processing. We cannot change the selections you made on the original form submitted.**

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, reaching maximum child age or losing full-time student status, they cannot continue to be covered under the EUTF plans. You are required to notify the EUTF and make these terminations when these events occur. Do not wait for open enrollment to submit these terminations.

Note: The Open Enrollment period for COBRA participants is also taking place during this time. Please refer to the EUTF website for information.

Monthly Premiums - EUTF Plans

**ALL BU'S EXCEPT BU12
HSTA VEBA ACTIVE EMPLOYEES WHO OPT TO TRANSFER TO EUTF PLANS (BU 05,45)
BU 05, 45 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011
EFFECTIVE JULY 1, 2013 THROUGH JUNE 30, 2014**

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
MEDICAL PLANS				
PPO – 90/10 Plan – HMSA Medical RSN Chiropractic	Self	\$376.37	\$2.15	\$378.52
	Two-Party	\$913.01	\$4.51	\$917.52
	Family	\$1,163.73	\$6.55	\$1,170.28
PPO – 80/20 Plan – HMSA Medical RSN Chiropractic	Self	\$345.19	\$2.13	\$347.32
	Two-Party	\$837.33	\$4.51	\$841.84
	Family	\$1,067.25	\$6.55	\$1,073.80
PPO – 75/25 Plan – HMSA Medical RSN Chiropractic	Self	\$308.75	\$2.13	\$310.88
	Two-Party	\$748.87	\$4.49	\$753.36
	Family	\$954.43	\$6.57	\$961.00
EUTF Prescription Drug – CVS Caremark	Self	\$70.37	\$0.63	\$71.00
	Two-Party	\$170.97	\$1.27	\$172.24
	Family	\$217.85	\$1.87	\$219.72
HMO – HMSA Medical Prescription Drug – CVS Caremark RSN Chiropractic	Self	\$488.94	\$2.74	\$491.68
	Two-Party	\$1,186.46	\$5.78	\$1,192.24
	Family	\$1,512.30	\$8.42	\$1,520.72
HMO – Kaiser Comprehensive Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$465.97	\$2.75	\$468.72
	Two-Party	\$1,131.67	\$5.77	\$1,137.44
	Family	\$1,443.07	\$8.45	\$1,451.52
HMO – Kaiser Standard Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$325.29	\$2.75	\$328.04
	Two-Party	\$789.79	\$5.77	\$795.56
	Family	\$1,006.95	\$8.45	\$1,015.40
Supplemental – HMSA Medical HMSA Supplemental Prescription Drug RSN Chiropractic	Self	\$225.49	\$2.75	\$228.24
	Two-Party	\$546.99	\$5.77	\$552.76
	Family	\$696.83	\$8.45	\$705.28
Supplemental – Royal State National Supplemental Prescription Drug RSN Chiropractic	Self	\$41.48	\$2.76	\$44.24
	Two-Party	\$103.04	\$5.76	\$108.80
	Family	\$114.54	\$8.42	\$122.96
DENTAL PLAN				
HDS Dental	Self	\$30.28	\$0.32	\$30.60
	Two-Party	\$60.56	\$0.64	\$61.20
	Family	\$99.64	\$0.96	\$100.60
VISION PLAN				
VSP Vision	Self	\$5.96	\$0.08	\$6.04
	Two-Party	\$11.04	\$0.12	\$11.16
	Family	\$14.42	\$0.18	\$14.60
LIFE INSURANCE*				
Royal State National Life Insurance	Employee	\$4.12	\$0.04	\$4.16

*Employer paid

Monthly Premiums - EUTF Plans

BU12
EFFECTIVE JULY 1, 2013 THROUGH JUNE 30, 2014

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
MEDICAL PLANS				
PPO – 90/10 Plan – HMSA Medical RSN Chiropractic	Self	\$313.03	\$2.13	\$315.16
	Two-Party	\$781.95	\$4.49	\$786.44
	Family	\$1,013.05	\$6.55	\$1,019.60
PPO – 80/20 Plan – HMSA Medical RSN Chiropractic	Self	\$287.39	\$2.13	\$289.52
	Two-Party	\$717.81	\$4.51	\$722.32
	Family	\$929.89	\$6.55	\$936.44
PPO – 75/25 Plan – HMSA Medical RSN Chiropractic	Self	\$257.07	\$2.13	\$259.20
	Two-Party	\$642.01	\$4.51	\$646.52
	Family	\$831.63	\$6.57	\$838.20
EUTF Prescription Drug – CVS Caremark	Self	\$51.34	\$0.62	\$51.96
	Two-Party	\$128.53	\$1.27	\$129.80
	Family	\$166.49	\$1.87	\$168.36
HMO – HMSA Medical Prescription Drug – CVS Caremark RSN Chiropractic	Self	\$407.19	\$2.77	\$409.96
	Two-Party	\$1,017.86	\$5.78	\$1,023.64
	Family	\$1,318.84	\$8.44	\$1,327.28
HMO – Kaiser Comprehensive Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$399.45	\$2.75	\$402.20
	Two-Party	\$997.95	\$5.77	\$1,003.72
	Family	\$1,292.71	\$8.45	\$1,301.16
HMO – Kaiser Standard Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$270.37	\$2.75	\$273.12
	Two-Party	\$675.19	\$5.77	\$680.96
	Family	\$874.39	\$8.45	\$882.84
Supplemental – HMSA Medical HMSA Supplemental Prescription Drug RSN Chiropractic	Self	\$178.31	\$2.77	\$181.08
	Two-Party	\$447.81	\$5.79	\$453.60
	Family	\$587.63	\$8.45	\$596.08
Supplemental – Royal State National Supplemental Prescription Drug RSN Chiropractic	Self	\$41.48	\$2.76	\$44.24
	Two-Party	\$103.04	\$5.76	\$108.80
	Family	\$114.54	\$8.42	\$122.96
DENTAL PLAN				
HDS Dental	Self	\$30.28	\$0.32	\$30.60
	Two-Party	\$60.56	\$0.64	\$61.20
	Family	\$99.64	\$0.96	\$100.60
VISION PLAN				
VSP Vision	Self	\$5.96	\$0.08	\$6.04
	Two-Party	\$11.04	\$0.12	\$11.16
	Family	\$14.42	\$0.18	\$14.60
LIFE INSURANCE*				
Royal State National Life Insurance	Employee	\$4.12	\$0.04	\$4.16

*Employer paid

Monthly Premiums - HSTA VB Plans

**BU 05, 45 FORMERLY UNDER THE HSTA VEBA
HSTA VB RATES
EFFECTIVE JULY 1, 2013 THROUGH JUNE 30, 2014**

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
MEDICAL PLANS				
HSTA VB - PPO - 90/10 Plan - HMSA Medical, CVS Drug, RSN Chiropractic, VSP Vision	Self	\$479.79	\$2.81	\$482.60
	Two-Party	\$1,160.53	\$5.91	\$1,166.44
	Family	\$1,479.65	\$8.63	\$1,488.28
HSTA VB - PPO - 80/20 Plan - HMSA Medical, CVS Drug, RSN Chiropractic, VSP Vision	Self	\$351.41	\$2.83	\$354.24
	Two-Party	\$849.01	\$5.91	\$854.92
	Family	\$1,082.33	\$8.63	\$1,090.96
HSTA VB - HMO - Kaiser Comprehensive Medical, Drug, RSN Chiropractic, VSP Vision	Self	\$415.85	\$2.83	\$418.68
	Two-Party	\$1,006.51	\$5.89	\$1,012.40
	Family	\$1,283.77	\$8.63	\$1,292.40
HSTA VB - Supplemental - HMSA Supplemental Medical, Drug, Vision RSN Chiropractic	Self	\$300.37	\$2.83	\$303.20
	Two-Party	\$725.97	\$5.91	\$731.88
	Family	\$925.63	\$8.61	\$934.24
DENTAL PLAN				
HSTA VB - HDS Dental	Self	\$30.28	\$0.32	\$30.60
	Two-Party	\$60.56	\$0.64	\$61.20
	Family	\$99.64	\$0.96	\$100.60
HSTA VB - HDS Supplemental Dental *	Self	\$16.08	\$0.32	\$16.40
	Two-Party	\$32.16	\$0.64	\$32.80
	Family	\$48.24	\$0.96	\$49.20
VISION PLAN				
HSTA VB - VSP Vision	Self	\$5.96	\$0.08	\$6.04
	Two-Party	\$11.04	\$0.12	\$11.16
	Family	\$14.42	\$0.18	\$14.60
LIFE INSURANCE**				
HSTA VB - Royal State National Life Insurance	Employee	\$4.12	\$0.04	\$4.16

*Rates may increase up to 5% effective July 1, 2013

**Employer paid

Schedule of Open Enrollment Informational Sessions for Active Employees

Date	Location	Room	Time
Apr 15	Honolulu	Neal S. Blaisdell Center ✧	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 16	Honolulu	Aloha Stadium Hospitality Room	8:30a-10a, 10:30a- 2p, 1p-2:30p, 3p-4:30p
Apr 17	Molokai	Mitchell Pauole Community Center	1p-2:30p, 3p-4:30p
Apr 18	Honolulu	Mission Memorial Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 19	University of Hawai'i West O'ahu	University of Hawai'i – West O'ahu College	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 22	Kona	Old Kona Airport	10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 23	Honolulu	Mission Memorial Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 24	Honolulu	Mission Memorial Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 25	Hilo	Aunt Sally's Lu'au Hale	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 26	Windward	Windward Community College	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 29	Hilo	Aunt Sally's Lu'au Hale	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 30	Pearl City	Leeward Community College	*8:30a-10a, *10:30a-12p, 1p-2:30p, 3p-4:30p
May 1	Kauai	War Memorial Convention Center	10:30a-12p, 1p-2:30p, 3p-4:30p
May 2	Kapolei	Kapolei Hale Conference Rooms A, B & C	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
May 3	University of Hawai'i at Manoa	UH Kuykendall Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
May 6	Kauai	War Memorial Convention Center	10:30a-12p, 1p-2:30p, 3p-4:30p
May 7	Maui	War Memorial Gymnasium	10:30a-12p, 1p-2:30p, 3p-4:30p
May 8	Maui	War Memorial Gymnasium	10:30a-12p, 1p-2:30p, 3p-4:30p

Informational Session presentation to start promptly at the designated start time.

Informational Session Locations

HAWAII - KONA	Old Kona Airport 75-5530 Kuakini Highway Kailua-Kona, HI 96740	HAWAII - HILO	Aunt Sally's Lu'au Hale 799 Piilani Street Hilo, HI 96720
KAUAI	War Memorial Convention Center 4191 Hardy Street Lihue, HI 96766	MOLOKAI	Mitchell Pauole Community Center 90 Ainoa Street Kaunakakai, HI 96748
MAUI	War Memorial Gymnasium 700 Halia Nakoa Street Wailuku, HI 96793		
OAHU	Neal S. Blaisdell Center Pikake Room 777 Ward Avenue Honolulu, HI 96814 ✧ Parking is at your own expense	Aloha Stadium Hospitality Room 99-500 Salt Lake Boulevard Honolulu, HI 96818	Kapolei Hale Conference Rooms A, B & C 1000 Uluohia Street Kapolei, HI 96707
	Leeward Community College * General Technology Room 105 96-045 Ala Ike Street Pearl City, HI 96782	Leeward Community College Theatre 96-045 Ala Ike Street Pearl City, HI 96782	
	Mission Memorial Auditorium 550 South King Street Honolulu, HI 96813	Windward Community College Hale Kuhina Room 115 45-720 Kea'ahala Road Kaneohe, HI 96734	
	University of Hawai'i at Manoa Kuykendall Auditorium 2445 Campus Road Honolulu, HI 96822	University of Hawai'i - West O'ahu College UHWO Campus Center - C208 Multi-Purpose Ballroom 91-1001 Farrington Highway Kapolei, HI 96707	

Employee and Dependent Eligibility

Eligibility for coverage is determined by Hawaii Statute and by the Administrative Rules adopted by the EUTF Board of Trustees. Requests for enrollments, terminations, and other changes must be submitted to the EUTF through your designated personnel officer. If you have any questions concerning eligibility provisions, you should refer to the Administrative Rules posted on the EUTF website, eutf.hawaii.gov. You can also call the EUTF Customer Service Call Center at 808-586-7390 or toll free at 1-800-295-0089 or email your inquiry to eutf@hawaii.gov.

Health Plans

Employee Eligibility: The following persons are eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- ▶ An eligible employee, including an elective officer of the State, county or legislature
- ▶ The surviving spouse, Domestic Partner or Civil Union Partner (DP/CUP) of an employee killed in the performance of duty, provided the spouse or DP/CUP does not remarry or enter into another domestic or civil union partnership
- ▶ The unmarried child of an employee killed in the performance of duty, provided the child is under age 19 and has no surviving parent

Dependent Eligibility: The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- ▶ The Employee's legal spouse, Domestic Partner or Civil Union Partner (DP/CUP)
- ▶ Your or your spouse's or DP/CUP's children under the age of 26 (for medical and prescription drug coverage). This includes children by birth, marriage, or adoption or legal guardianship to age 18. For dental and vision coverage dependent children are covered to age 19 and from age 19 to 24 if they are unmarried and full time students
- ▶ Coverage can be continued for an unmarried child, regardless of age, who is incapable of self-support due to mental/physical incapacity that existed prior to the child reaching age 19
- ▶ Child covered by terms of a qualified medical child support order (QMCSO)

Group Life Insurance

Employees are eligible for the group life insurance plan offered by the EUTF.

Special Eligibility Requirements for Domestic and Civil Union Partners

Domestic Partner: Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

1. Intend to remain in a domestic partnership with each other indefinitely.
2. Have a common residence and intend to reside together indefinitely.
3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care.
4. Neither are married or a member of another domestic partnership.
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii.
6. Both at least 18 years of age and mentally competent to contract.
7. Consent to the domestic partnership has not been obtained by force, duress or fraud.
8. Both sign and file a notarized declaration of domestic partnership (affidavit) with the EUTF.

Civil Union Partner: A person who has entered into a civil union under the rules established by the State of Hawaii Department of Health. You may also enroll a civil union partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children.

NOTE: There may be Federal Income Tax consequences with employer paid coverage for domestic or civil union partners: If your domestic or civil union partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic or civil union partner will be deemed taxable income and reported to you on the appropriate federal tax form. Consult your tax advisor to determine your domestic or civil union partner's status. If you determine that your domestic or civil union partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available along with information/instructions on the EUTF website, eutf.hawaii.gov) to the EUTF.

Enrollment

To enroll, you must complete an EUTF Enrollment Form for Active Employees (EC-1 or EC-1H) (see pages 50-57). If you do not enroll eligible members of your family within 30 days of when you or they first become eligible, you must wait until the next Open Enrollment period to do so. The plan year for active employees begins July 1 and ends June 30 of the following year.

ID Cards

After you enroll for the first time, you will receive identification cards from the plans as follows:

- ▶ HMSA, Kaiser and CVS Caremark issue an ID card for each enrolled member of a family upon initial enrollment.
- ▶ HDS will issue two identical ID cards showing the name of the subscriber.
- ▶ VSP and RSN do not issue ID cards.

Dual Family Enrollment (Two EUTF Employees Family Enrollments) Is Not Allowed

If both you and your spouse, domestic partner or civil union partner are employee-beneficiaries, only one of you may enroll in an EUTF Family plan; or if no other dependents are involved, both may enroll in EUTF Self plans. Dual enrollment in EUTF family plans is not allowed under EUTF Administrative Rule 4.03. If your spouse or domestic partner or civil union partner has coverage outside of the EUTF that provides a family coverage through another employer, this rule does not preclude you from also enrolling in a family coverage plan to cover your spouse, domestic partner or civil union partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

Medicare Part B Premium Reimbursement

Retirees and their spouses, domestic partners or civil union partners who are enrolled in an EUTF RETIREE medical plan are eligible for Medicare Part B premium reimbursements. If you are enrolled in an EUTF active employee medical plan, you are not eligible for Medicare Part B reimbursement. However, if you are an active employee, enrolled in Medicare Part B and covered by the EUTF retiree medical plan through your spouse/DP/CUP, your spouse/DP/CUP is entitled to Medicare Part B reimbursement for you.

Change of Coverage – Special Enrollment Period due to a Qualifying Event

You are eligible to change coverage outside the Open Enrollment period for the following reasons:

1. You marry and want to enroll your spouse and/or newly eligible dependent children.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide appropriate documents verifying the adoption in order to have the application accepted. To enroll a newborn you do not need to attach a copy of the birth certificate or submit the social security number.

3. You have a change in family status involving the loss of eligibility of a family member (e.g., legal separation, divorce, death, child turns age 26).
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

To change your coverage, you should complete Form EC-1 or EC-1H and submit it through your employer representative within 30 days of the date of the change. Generally, deletion of dependents is effective on a prospective basis, depending upon receipt of the application by the EUTF.

Dependent children are automatically terminated from the medical and prescription drug plans as of the end of the pay period they attain age 26 and do not require the completion of an application to delete coverage. For dental and vision, coverage for the dependent terminates at the age of 24 if the dependent is a full time student or 19 if not, or after an application has been submitted to delete coverage for the dependent. If events are filed within 30 days of the qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. These events include: Adoption, Placement for Adoption (if sooner), Birth, Guardianship, New Eligible Student, Marriage, New Domestic Partner, New Civil Union Partner, Reinstatement in Employment, and Return from Authorized Leave of Absence (if not currently enrolled). See Common Qualifying Events on page 16.

End of Coverage

Common situations resulting in loss of coverage for you and your dependents are:

1. You voluntarily terminate coverage.
2. You do not make required premium payments (if applicable).
3. You die, subject to exceptions.
4. You fail to comply with the EUTF Administrative Rules.
5. You file fraudulent claims.

Coverage for your children, step-children, or spouse / DP / CUP will end if:

1. Your dependent is no longer eligible for coverage such as due to a divorce or legal separation with respect to step-children or your child reaches the limiting age.
2. Your surviving spouse, domestic or civil union partner remarries.

Effective Dates of Coverage for New Hires and Newly Eligible

You have a choice of when you would like your coverage to begin. You may choose either your date of hire or the first day of the first pay period from your date of hire or the first day of the second pay period from your date of hire. This rule also applies to some mid- year changes. If you become newly eligible (i.e., part time to full time employee), your effective date of coverage will be the date the change in employment status occurs.

Although your coverage begins on the date you select, if you need to fill a prescription or go to the doctor prior to receiving your ID cards you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks this email daily and will contact the carrier to rush your enrollment after it receives the EC-1 or EC-1H from your employer.

If you were enrolled in the EUTF with your previous public employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately - so you have no break in coverage. (See Transfer of Employment on page 13.)

Transfer of Employment

If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin in your new position.

Effective Date of Termination

In general, when an event causes you or your dependent's coverage to terminate, such termination will be effective on the first day of the first pay period following the occurrence of the event, e.g., divorce, end of domestic or civil union partnership, death, surviving spouse/partner remarries, or child ceases to be eligible for coverage. There may be certain instances in which the effective date of termination is different. You may obtain additional information by referring to the EUTF Administrative Rules that are posted on the EUTF website, eutf.hawaii.gov.

Rejection of Enrollment

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria detailed in the EUTF Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required.

An enrollment application shall be rejected if:

1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the rules (see Common Qualifying Events on page 16);
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the EUTF; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified by mail of the rejection of any enrollment application.

Premium Conversion Plan – State of Hawaii Employees Only

Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at <http://dhrd.hawaii.gov>.

By electing to participate in the Premium Conversion Plan (PCP), please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or cancel your participation in the PCP during the Open Enrollment period or as provided under number 2 below.
2. If you have an allowable change in status (marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay (otherwise, changes can be made only during the Open Enrollment period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.
3. Allowable changes/cancellations shall become effective as soon as administratively possible, on a **prospective** basis, after you file your forms (e.g. the beginning of the pay period following receipt of your form). So to avoid the risk of losing money, you need to file the forms as soon as possible. Changes in pre-tax payroll deductions are always done after receipt of the PCP-2 forms; never retroactively.

4. Your PCP payroll deduction, in the absence of a PCP allowable change in status, cannot be changed for the current plan year.
5. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP payroll deduction will still remain in effect through the end of the plan year, and your payments will be forfeited, until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

Administrative Appeals

Under EUTF Administrative Rule 2.04, a person aggrieved by one of the following decisions by the EUTF may appeal to the EUTF Board of Trustees (Board) for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

The first step in the appeal process is an appeal to the EUTF administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within thirty days of the date of the decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the EUTF administrator nor the Board shall be required to hear any appeal that is filed after the thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;
2. A description of the decision with respect to which relief is requested, including the date of the decision;
3. A statement of the relevant and material facts; and
4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the EUTF administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the Board. A written appeal to the Board must be filed in duplicate in the EUTF's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;
2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
3. A description of the decision with respect to which relief is requested, including the date of the decision;
4. A complete statement of the relevant and material facts;
5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the Board may reject any appeal that does not contain the foregoing information.

The Board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The Board shall grant or deny the appeal within a reasonable amount of time. The Board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the Board may set such hearing before the Board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the Board to hear the matter in question. Please note that nothing in the EUTF Administrative Rules requires the Board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the EUTF Administrative Rules by submitting such a waiver in writing to the EUTF's office. The Board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

For emergency appeals, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

Keep this to refer to throughout the year.

Common Qualifying Events That Allow Enrollment Changes For Active Employees

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
Acquisition of Coverage (employee gets coverage from another plan and wishes to cancel EUTF plans)	Within 30 days from effective date of gaining coverage elsewhere	None	If coverage is gained 1 st of month, EUTF coverage ends day before 1 st . If coverage is gained 16 th of month, EUTF coverage ends 15 th	N/A
Birth (employee wishes to add newborn to EUTF plans)	Within 30 days from date of birth	Birth certificate only if child has a different last name from employee. Social Security Number within 60 days of date of birth	Employee can choose: birth date, beginning of next pay period after birth date, or 2nd pay period after birth date	No
Court Order (to cover child)	EUTF receives the order directly from the Child Support Enforcement Agency (CSEA). No EC-1/EC-1H is required if employee is already enrolled in EUTF plans	CSEA notice	Effective date on CSEA notice	No
Death	As soon as reasonably practical	Death certificate or copy of obituary as soon as available	Date of death	N/A
Divorce (employee must terminate spouse's or civil union partner's coverage)	Within 30 days of date of divorce	Pages 1 and 2 of divorce decree, along with signature page. If children are involved, those pages that outline health benefits for children	Coverage ends last day of pay period in which divorce date occurs	No
Guardianship (employee wishes to add child to EUTF plans)	Within 30 days from date of guardianship	Guardianship decree	Employee can choose: guardianship date, beginning of next pay period after guardianship date, or 2nd pay period after guardianship date	No

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
Legal Separation (employee must terminate spouse's EUTF coverage)	Within 30 days from date of legal separation	Court document establishing legal separation, including any pages regarding health benefits to children	Coverage ends last day of pay period of date of legal separation	No
Leave of Absence Without Pay (employee may continue coverage by paying his/her share of premium or terminate coverage)	Within 30 days from beginning of LWOP to waive plans. To reenroll after LWOP EC-1/EC- 1H must be submitted within 30 days of return from LWOP	Form L-1 completed by employer (available on EUTF's website)	If employee cancels plans, last day of pay period in which LWOP begins	No
Loss of Coverage (employee and/or dependent lost coverage from a non-EUTF plan, wishes to enroll in EUTF plans, and is currently enrolled in an EUTF plan)	Within 30 days from loss of other coverage	Loss of coverage letter from previous employer / carrier detailing type of coverages lost (i.e., medical, dental, drug, vision), date of loss of coverage, and names of any covered dependents	Day following loss of coverage from other plan	N/A
Marriage (employee wishes to enroll new spouse in EUTF plans)	Within 30 days from date of marriage (effective date is date personnel office receives EC-1/EC-1H. If notification submitted prior to marriage, effective date is date of marriage)	None	Employee can choose: Date form turned into personnel, beginning of next pay period after turning in form to personnel or 2nd pay period after turning form into personnel	No
Newly Eligible Student (employee wishes to add child in dental or vision plan because child became a full time student and is between the ages of 19 and 24)	Within 30 days from date of school start date	Student certification from an accredited college on school letterhead with registrar's signature confirming full time status (for dental and vision coverage). Transcripts not acceptable	Employee can choose: Date child becomes full time student, beginning of next pay period after becoming full time student, or 2nd pay period after becoming full time student	No

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
New Hire (new employee wishes to enroll in EUTF plans)	Within 30 days of date of new hire	1) Adult children through age 25 may be included in medical and prescription drug 2) Student Certificate if enrolling a dependent 19 or older in dental and vision (on school letterhead, signed by registrar) 3) Birth certificate if enrolling a dependent with a different last name and Social Security Number within 60 days of new hire date	Employee can choose: New hire date, beginning of next pay period after new hire date, or 2nd pay period after new hire date	N/A
New Domestic Partner (employee wishes to enroll new domestic partner in EUTF plans)	Within 30 days from date of notarized signature (event date is considered date of notarization)	Notarized Declaration of Domestic Partnership, Affidavit of Dependency (notarized if IRS qualified), Premium Conversion Plan form	Employee can choose: Date of notarization of Declaration of Domestic Partnership, beginning of next pay period after notary date, or 2nd pay period after notary date	No
New Civil Union Partner (employee wishes to enroll new civil union partner in EUTF plans)	Within 30 days from date of civil union	Civil union certification (on line proof accepted), Affidavit of Dependency, Premium Conversion Plan form	Employee can choose: Civil union date, beginning of next pay period after civil union date, or 2nd pay period after civil date	No
Termination of Domestic Partnership (employee must terminate domestic partner or civil union partner)	Within 30 days of termination of partnership	For domestic partnership, Declaration of Termination of Domestic Partnership. For civil union, see divorce	End of pay period in which the Declaration of Termination of Domestic Partnership form was received by EUTF	No
Voluntary Cancellation, including dependents (employee wishes to cancel from all EUTF plans or cancel dependents from all EUTF plans with no qualifying event)	At any time	(if enrolled in PCP, generally voluntary cancellations do not allow changes to payroll deductions)	Employee chooses date, either 1st or 16th of month	N/A

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
<p><i>Voluntary Cancellation:</i> Although current EUTF rules allow for voluntary termination at any time, Premium Conversation Plan (PCP) enrollment cannot be terminated/changed until the next open enrollment for voluntary cancellations. Therefore, the employee contribution will continue to be collected, but health benefit plan coverage will be terminated.</p>				

Note: For termination and transfer of employment or bargaining unit changes or death the employer is required to notify EUTF immediately of the termination, transfer, BU change, or death.

Required Notices

The following required notices are available for viewing at EUTF's website at eutf.hawaii.gov.

If you wish to have hard copies of any of these notices, send EUTF an email at eutf@hawaii.gov. Indicate which notice(s) you want to receive and include your name and mailing address. Or, you may call our Customer Service Call Center at 808-586-7390 or Toll Free at 1-800-295-0089. All requested notices will be mailed to you free of charge.

- **Qualified Medical Child Support Order** – This is to notify participants that your health insurance plan honors qualified medical child support orders (QMCSOs), which means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan.
- **National Medical Support Notices** – The EUTF (your health benefits plan administrator) also honors qualified National Medical Support Notices (NMSNs), which are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order.
- **Continuation of Group Health Coverage Under COBRA: Initial Notice** – In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child. The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs**. That notice should be sent to your Employer via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA contact the EUTF Plan Administrator.

For actives enrolled in the CVS Caremark prescription drug plan:

- **HIPAA Notice: Notice of Privacy Rights** – This notice describes how your prescription drug information may be used and disclosed and how you can get access to this information. Refer to page 22 for a copy of the notice.

- **Notice of Creditable and Non-Creditable Coverage** – Refer to page 49 for a description.

If you wish to have hard copies of any of the following notices, please contact Kaiser or HMSA (contact information on page 59 of this guide).

- **Women's Health & Cancer Rights Act** – This notice includes information regarding benefits that your health insurance plan is required to provide by the Women's Health and Cancer Rights Act of 1998 for mastectomy-related services.
- **Newborns' & Mothers' Health Protection Act** – This is to notify participants that group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section.
- **HIPAA Initial Notice: Notice of Privacy Rights** – This notice describes how your medical information may be used and disclosed and how you can get access to this information.
- **Certificate of Creditable Coverage and Preexisting Conditions** – A certificate of creditable coverage shall be provided when your coverage ends. This notice also includes information regarding regulations on preexisting conditions.
- **Patient Protection Disclosure** – This notice provides individuals with information regarding their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

HIPAA Notice: Notice of Privacy Rules

Effective date of this notice is January 1, 2013.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), governs all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information.

The EUTF acknowledges that your medical and health information is personal – and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations or persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- Make sure that medical information that identifies you is kept private,
- Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- Retain copies of the notices the EUTF issues to you,
- Retain any written acknowledgments that you received the notices, or document the EUTF's good faith efforts to obtain such written acknowledgments from you, and
- Follow the terms of the notice that is currently in effect.

HIPAA also requires the EUTF to tell you about:

- The EUTF's uses and disclosures of your medical information,
- Your privacy rights with respect to your medical information,
- Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the “use and disclosure” of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, all of the ways the EUTF is allowed to use and disclose your medical information will fall into one of the categories listed.

The following categories DO NOT REQUIRE the EUTF to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

For Treatment: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child’s dentist to your child’s orthodontist so that the orthodontist may ask the dentist for your child’s dental X-rays.

For Payment: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

For EUTF Operations: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments, improvement activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

As Required By Law: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF’s compliance with federal privacy regulations (this notice).

To Avert a Serious Threat to Health or Safety: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment, health care operations and EUTF operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan.

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may disclose your medical information to the Hawaii Medical Service Association, Kaiser Permanente and Kaiser Health Plan, Hawaii Dental Service, Vision Service Plans, ChiroPlan Hawaii or Royal State Insurance in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or disenrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied claim or other matter to the EUTF's Board of Trustees, the EUTF may disclose your medical information to the EUTF's Board of Trustees and its staff, consultant, and legal counsel as may be necessary to allow the EUTF's Board of Trustees to make a decision on your appeal. The EUTF may also disclose your medical information to the EUTF's Board of Trustees for plan administration functions, including such functions as quality assurance and auditing or monitoring the operations of group health plans that are part of the EUTF.

Public Health Activities: the EUTF may disclose your medical information to a public health authority for the purpose of preventing or controlling disease, injury or disability or to report child abuse or neglect.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- About a death the EUTF believes might be the result of criminal conduct, and
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category **REQUIRES** the EUTF to obtain your written authorization for the use or disclosure.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category **REQUIRES** that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

Family or Friends Involvement: the EUTF may disclose your medical information to family members, other relatives, or your friends if:

- The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and

- You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy of your medical information contained in a “designated record set,” for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF’s health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you in accordance with the time limits required under Part II of Chapter 92F, Hawaii Revised Statutes, and the rules enacted thereunder. Under those laws, the EUTF will generally provide a copy of your medical information to you within ten (10) business or working days. However, in certain circumstances, the EUTF may be entitled to additional time to respond to your request.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit the completed request form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing the information to you or for other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Privacy Officer. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within twenty (20) business or working days, or notify you that your request has been denied.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask the EUTF to amend information that:

Is not part of the medical information kept by or for the EUTF,

Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,

Is not part of the information which you would be permitted to inspect and copy, or

Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

The EUTF has 60 days from the date it receives your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or disclosures for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the EUTF not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

In your request, you must indicate:

- What information you want to limit,
- Whether you want to limit the EUTF’s use, disclosure, or both, and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that the EUTF communicate with you about your medical information or other medical matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

To request confidential communications, you must submit a written request to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. The EUTF will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice.

To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order appointing the person as the your conservator or guardian, or
- An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you — as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than

the minimum amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,
- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

This notice does not apply to medical information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

You may also file a complaint with the Secretary of the Department of Health and Human Services at:

Secretary, DHHS

Hubert H. Humphrey Building

200 Independence Avenue S.W.

Washington, D.C. 20201

You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization. You should understand

that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

Questions?

If you have any questions about this notice, contact the EUTF Privacy Officer, at the address below.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the EUTF Privacy Officer at the following address:

Mailing Address:	P.O. Box 2121, Honolulu, HI 96805
Location Address:	201 Merchant Street, Suite 1520, Honolulu, HI 96813
Local number:	808-586-7390, Toll-Free number: 1-800-295-0089

Active Benefit Plan Summaries

The following section provides condensed summaries of the health plans and life insurance coverage available for actives. Remember that certain limitations and exclusions apply to all insurance plans. More complete information on the plans can be obtained directly from the carriers or from the EUTF website at eutf.hawaii.gov. If there should be any discrepancy between the information provided in this Reference Guide and that contained in the carrier's Guide to Benefits, the language in the carrier's Guide to Benefits will take precedence.

Medical and Prescription Drug Plan Options

Medical coverage is important to everyone. The Plans offered by the EUTF provide preventive care benefits to keep you healthy and many other benefits to help during those times when you are not. The EUTF offers the following Plan options:

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Preferred Provider Organization (PPO) 75/25 Plan (new)
- Prescription Drug Plan
- Health Maintenance Organization (HMO) Plans
- Supplemental Medical Plans for those who are covered under another plan, such as a spouse's plan

The HSTA VB medical plan options, including prescription drug, are:

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Health Maintenance Organization (HMO) Plan
- Supplemental Medical Plan for those who are covered under another plan, such as a spouse's plan

Understanding the Plan Designs

Preferred Provider Organization Plans (PPO) - EUTF 90/10, 80/20, or 75/25 or HSTA VB 90/10 or 80/20

A PPO plan is a medical plan that is based on a network of preferred medical providers who have contracts with the carrier. Coverage is also available if you go to a provider who is not in the network. A PPO gives you the flexibility to visit the providers you choose – inside or outside of the Plan's network. However, your out of pocket medical costs will be lower if you receive care from an in-network provider or facility. The numbers in the plan titles – 90/10, 80/20, or 75/25 – refer to the percent of eligible charges that the carrier pays for most network services – 90%, 80%, or 75% - and the amount the employee is responsible for, 10%, 20%, or 25%. It's important to note that when you participate in a PPO, you are responsible for asking if your medical provider is in the network or not. If you use an out-of-network provider, your out of pocket costs will be higher since most out-of-network expenses are paid at 70%, 75%, or 80% and you would be responsible for 30%, 25%, or 20% of the covered expense. Also, you'll often be responsible for submitting your own claims.

Health Maintenance Organization (HMO) - EUTF HMSA HMO or Kaiser Comprehensive or Standard HMO (new) or HSTA VB Kaiser Comprehensive HMO

Under an HMO, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMOs don't cover the cost of services you receive from doctors or other providers outside of the HMO's network. With an HMO, there are no deductibles or claim forms. After a copayment for each office visit, most medical expenses are covered at 100%. You must select a Primary Care Provider to coordinate your care.

Supplemental Medical Plan (Dual Coverage) - EUTF or HSTA VB HMSA Supplemental or Royal State National Supplemental

If you have a medical plan through your non-State/County spouse or another source, you can choose these plans. Covered medical expenses that are not covered by the other primary medical plan such as that plan's copays or coinsurance are paid under these plans. Covered expenses include copays for prescription drugs so there is not a separate drug plan offered with the supplemental plans. You can enroll in a supplemental plan **only** if you have another medical plan coverage not provided through the State or counties.

Chiropractic Plan Benefits (Royal State National (RSN))

Royal State National Insurance Company, Ltd., through ChiroPlan Hawaii, Inc. is the provider of the chiropractic benefits. The chiropractic benefit is packaged with all active medical plans.

The plan benefits include the initial exam, any necessary x-rays (when taken in a ChiroPlan provider's office), therapeutically necessary chiropractic treatment and therapeutic modalities. For EUTF, the co-payment is \$15 per visit up to 20 visits per calendar year. For HSTAVB, the co-payment is \$12 per visit up to 20 visits per calendar year. Chiropractic services must be received by a credentialed ChiroPlan Provider. A complete list of ChiroPlan doctors and plan information may be obtained from the EUTF website: eutf.hawaii.gov Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

Medical Plan Coverage Chart (HMSA, Kaiser, RSN)

Plan Design	EUTF 90/10 PPO Plan		EUTF 80/20 PPO Plan	
Carrier	HMSA		HMSA	
General	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single/Family	None	\$100 per person; \$300 per family	None	
Out-of-pocket limit Single/Family	\$2,000 / \$6,000		\$2,500 / \$7,500	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Policy Year Benefit Maximum	None		None	
Physician Services	YOU PAY:		YOU PAY:	
Primary Care Office Visit	10%	30%	\$14	\$14
Specialist Office Visit	10%	30%	\$14	\$14
Routine physical exams	No Charge	No Charge*	No Charge	No Charge
Screening Mammography	No Charge	30%*	No Charge	No Charge
Immunizations	No Charge	No Charge*	No Charge	No Charge
Well Baby Care Visits	No Charge	30%*	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	10%	10%
Second opinion – surgery	10%	30%	\$14	\$14
Emergency Room (ER care)	10%	10%*	\$20	\$20
Ambulance	10%	30%	20%	20%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	20%
Ancillary Services	10%	30%	20%	20%
Physician services	10%	30%	\$20	\$20
Surgery	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Diagnostic Lab	10%	30%	No Charge	No Charge
Diagnostic X-ray	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Mental Health Services				
Inpatient Care	10%	30%	20%	20%
Outpatient Care	10%	30%	20%	20%
Other Services				
Durable Medical Equipment	10%	30%	20%	20%
Home Health Care	No Charge	30%	20%	20%
Hospice Care	No Charge	Not Covered	No Charge	No Charge
Nursing Facility - Skilled Care	10%, 120 days / CY	30%, 120 days/ CY	20%, 120 days / CY	20%, 120 days / CY
Physical & Occupational Therapy	10%	30%	20%	20%
Notes:	*Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 38.		For prescription drug coverage, refer to the PPO plan on page 38.	

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Type	EUTF 75/25 PPO Plan (New)		Supplemental	
Carrier	HMSA		Royal State	HMSA
General	In-Network	Out-of-Network		
Annual Deductible Single/Family	\$300 / \$900		None/None	None/None
Annual Out-of-pocket limit Single/Family	\$5,000 / \$15,000		None	\$10,000
Lifetime Benefit Maximum	None		None	None
Policy Year Benefit Maximum	None		Medical svcs: \$3,100; Rx: \$200/\$600	None
Physician Services	YOU PAY:		YOU PAY:	YOU PAY:
Primary Care Office Visit	\$20*	\$20*	Co-pay covered	50%
Specialist Office Visit	\$20*	\$20*	Co-pay covered	50%
Routine physical exams	No Charge	No Charge	Co-pay covered	Not covered
Screening Mammography	No Charge	No Charge	Co-pay covered	No Charge (In-network): 50% (Out-of-Network)
Immunizations	No Charge	No Charge	Co-pay covered	50%
Well Baby Care Visits	No Charge	No Charge	Co-pay covered	No Charge (In-network): 50% (Out-of-Network)
Maternity	25%	25%	Co-pay covered	Same as any other condition
Second opinion – surgery	\$20*	\$20*	Co-pay covered	50%
Emergency Room (ER care)	\$100	\$100	Co-pay covered	50%
Ambulance	25%	25%	Co-pay covered	50%
Inpatient Hospital Services				
Room & Board	25%	25%	Co-pay covered	50%
Ancillary Services	25%	25%	Co-pay covered	50%
Physician services	25%	25%	Co-pay covered	50%
Surgery	25%	25%	Co-pay covered	50%
Anesthesia	25%	25%	Co-pay covered	50%
Outpatient Services				
Chemotherapy/ Radiation Therapy	25%	25%	Co-pay covered	50%
Surgery	25%	25%	Co-pay covered	50%
Diagnostic Lab	No Charge	No Charge	Co-pay covered	50%
Diagnostic X-ray	25%	25%	Co-pay covered	50%
Anesthesia	25%	25%	Co-pay covered	50%
Mental Health Services				
Inpatient Care	25%	25%	Co-pay covered	50%
Outpatient Care	25%	25%	Co-pay covered	50%
Other Services				
Durable Medical Equipment	25%	25%	Co-pay covered	50%
Home Health Care	25%	25%	Co-pay covered	50%
Hospice Care	No Charge	No Charge	Co-pay covered	No Charge (In-network): Not Covered (Out-of-Network)
Nursing facility - Skilled Care	25%	25%	Co-pay covered	50%, 120 days / CY
Physical & Occupational Therapy	25%	25%	Co-pay covered	50%
Notes:	*Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 38		*Refer to Reimbursement information under Drug Plans on page 38	*Refer to Reimbursement information under Drug Plans on page 38

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Type Plan Design	Comprehensive	HMO Standard (New)	EUTF HMO
Carrier General	Kaiser*	Kaiser*	HMSA
Deductible Single/Family	None/None	None/None	None/None
Out-of-pocket limit Single/Family	\$2,000 / \$6,000	\$2,500 / \$7,500	\$1,500 / \$4,500
Lifetime Benefit Maximum	None	None	None
Policy Year Benefit Maximum	None	None	None
Physician Services	YOU PAY:	YOU PAY:	YOU PAY:
Primary Care Office Visit	\$15	\$20	\$15
Specialist Office Visit	\$15	\$20	\$15
Routine physical exams	No Charge	No Charge	\$15
Screening Mammography	No Charge	No Charge	No Charge
Immunizations	No charge	No charge	No Charge
Well Baby Care Visits	No Charge	No Charge	No Charge
Maternity	No charge for routine prenatal visits and one postpartum visit	No charge for routine prenatal visits and one postpartum visit	No Charge, Routine Pre/Post Natal Care & Delivery
Second opinion – surgery	\$15	\$20	\$15
Emergency Room (ER care)	\$50	\$100	\$25
Ambulance	20%	20%	20%
Inpatient Hospital Services			
Room & Board	No Charge	15%	No Charge
Ancillary Services	No Charge	15%	No Charge
Physician services	No Charge	15%	No Charge
Surgery	No Charge	15%	No Charge
Anesthesia	No Charge	15%	No Charge
Outpatient Services			
Chemotherapy/ Radiation Therapy	\$15	20%	\$15
Surgery	\$15	15%	\$15
Diagnostic Lab	\$15/ department/ day	\$10/ department/ day for basic; 20% for specialty	No Charge
Diagnostic X-ray	\$15/ department/ day	\$10/ department/ day for basic; 20% for specialty	\$15 per X-ray
Anesthesia	\$15	15%	\$15
Mental Health Services			
Inpatient Care	No Charge	15%	No Charge
Outpatient Care	\$15	\$20	No Charge
Other Services			
Durable Medical Equipment	20%	50%	20%
Home Health Care	No Charge	No Charge	No Charge
Hospice Care	No Charge	No Charge	No Charge
Nursing facility - Skilled Care	No Charge, 100 days/ benefit period	15%, 60 days/ benefit period	No Charge, 100 days/ CY
Physical & Occupational Therapy	\$15	\$20	\$15 (Outpatient)
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 38.		For prescription drug coverage, refer to the HMO plan on page 38.

*For Kaiser members only:

- Except for certain situations described in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
- Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – HSTA VB

Plan Design	HSTA VB 90/10 PPO Plan		HSTA VB 80/20 PPO Plan	
Carrier	HMSA		HMSA	
General	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single/Family	None	\$100 per person; \$300 per family	None	
Out-of-pocket limit Single/Family	\$2,000 / \$6,000		\$2,500 / \$7,500	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Policy Year Benefit Maximum	None		None	
Physician Services	YOU PAY:		YOU PAY:	
Primary Care Office Visit	10%	30%	20%	20%
Specialist Office Visit	10%	30%	20%	20%
Routine physical exams	No Charge	No Charge*	No Charge	No Charge
Screening Mammography	No Charge	30%*	No Charge	No Charge
Immunizations	No Charge	30%	20%	20%
Well Baby Care Visits	No Charge	30%*	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	20%	20%
Second opinion – surgery	10%	30%	20%	20%
Emergency Room (ER care)	10%	10%*	20%	20%
Ambulance	10%	30%	20%	20%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	20%
Ancillary Services	10%	30%	20%	20%
Physician services	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Diagnostic Lab	10%	30%	No Charge	No Charge
Diagnostic X-ray	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Mental Health Services				
Inpatient Care	10%	30%	20%	20%
Outpatient Care	10%	30%	20%	20%
Other Services				
Durable Medical Equipment	10%	30%	20%	20%
Home Health Care	No Charge	30%	No Charge	No Charge
Hospice Care	No Charge	Not Covered	No Charge	No Charge
Nursing Facility - Skilled Care	10%, 120 days / CY	30%, 120 days / CY	20%, 120 days / CY	20%, 120 days / CY
Physical & Occupational Therapy	10%	30%	20%	20%
Notes:	For prescription drug coverage, refer to the PPO plan on page 39		For prescription drug coverage, refer to the PPO plan on page 39	

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – HSTA VB continued

Plan Type	HMO Comprehensive	Supplemental
Carrier	Kaiser*	HMSA
General		
Deductible Single/Family	None/None	None/None
Out-of-pocket limit Single/Family	\$2,000/ \$6,000	None
Annual Benefit Maximum	None	\$2,000,000
Lifetime Benefit Maximum	None	None
Policy Year Benefit Maximum	None	None
Physician Services	YOU PAY:	YOU PAY:
Primary Care Office Visit	\$15	10%
Specialist Office Visit	\$15	10%
Routine physical exams	No Charge	10%
Screening Mammography	No Charge	No Charge
Immunizations	No Charge	10%
Well Baby Care Visits	No Charge	No Charge
Maternity	No charge for routine prenatal visits and one postpartum visit	10%; plan limitations apply
Second opinion – surgery	\$15	10%
Emergency Room (ER care)	\$50	10%
Ambulance	20%	10%
Inpatient Hospital Services		
Room & Board	No Charge	10%; plan limitations apply
Ancillary Services	No Charge	10%
Physician services	No Charge	10%
Surgery	No Charge	10%
Anesthesia	No Charge	10%
Outpatient Services		
Chemotherapy/ Radiation Therapy	\$15	10%
Surgery	\$15	10%
Diagnostic Lab	\$15/ department/ day	10%
Diagnostic X-ray	\$15/ department/ day	10%
Anesthesia	\$15	10%
Mental Health Services		
Inpatient Care	No Charge	10%
Outpatient Care	\$15	10%
Other Services		
Durable Medical Equipment	20%	10%
Home Health Care	No Charge	10%
Hospice Care	No Charge	10%; participating provider only
Nursing facility - Skilled Care	No Charge, 100 days / benefit period	10%, 120 days / CY
Physical & Occupational Therapy	\$15	10%
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 39	Refer to Reimbursement information under Drug Plans on page 39

*For Kaiser members only:

- Except for certain situations described in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
- Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

PPO and HMO Prescription Drug Plans – EUTF

COVERAGE	PPO Prescription Drug Plan Caremark*		HMO Prescription Drug Plan		
			Kaiser Comprehensive	Kaiser Standard	Caremark
RETAIL PRESCRIPTION PROGRAM (30 day supply)	Participating Pharmacy**	Nonparticipating Pharmacy**	Copayment up to	Copayment up to	In-Network
Generic	\$5 copayment	\$5 + 20% of eligible charges	\$15	\$5 maintenance; \$10 other generic	\$5
Preferred Brand Name	\$15 copayment	\$15 + 20% of eligible charges	\$15	\$35	\$15
Other Brand Name	\$30 copayment	\$30 + 20% of eligible charges	\$15	\$35	\$30
Injectables and Specialty Drug	20% of eligible charges; Up to \$250 maximum; \$2,000 out-of-pocket maximum per plan year; \$30 copay oral oncology specialty medications	Not a benefit	\$15	\$5 maintenance / \$10 other generic / \$35 brand, if requires skilled administration by medical personnel - \$20 per dose	20% of eligible charges; Up to \$250 maximum; \$2,000 out-of-pocket maximum per plan year; \$30 copay oral oncology specialty medications
Insulin					
Preferred Insulin	\$5 copayment	\$5 + 20% of eligible charges	\$15	\$35 brand insulin	\$5
Other Insulin	\$15 copayment	\$15 + 20% of eligible charges	\$15	\$10 generic insulin	\$15
Diabetic Supplies					
Preferred Diabetic Supplies	No copayment	No copayment	\$15	50% of applicable charges	No copayment
Other Diabetic Supplies	\$15 copayment	\$15	\$15	50% of applicable charges	\$15
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)					
Generic	\$10 copayment	Not a benefit	\$30	\$10	\$10
Preferred Brand Name	\$35 copayment	Not a benefit	\$30	\$20	\$35
Other Brand Name	\$60 copayment	Not a benefit	\$30	\$70	\$60
Insulin					
Preferred Insulin	\$10 copayment	Not a benefit	Not Available through Mail Order	Not Available through Mail Order	\$10
Other Insulin	\$35 copayment	Not a benefit			\$35
Diabetic Supplies					
Preferred Diabetic Supplies	No copayment	Not a benefit	\$30	50% of applicable charges	No copayment
Other Diabetic Supplies	\$35 copayment	Not a benefit	\$30	50% of applicable charges	\$35

For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed \$15 per prescription drug (RX) up to \$200 if enrolled in single coverage or \$600 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Policy Year Maximum Benefit Payable.

For EUTF Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed \$20 per prescription drug (RX) for generic and preferred brand name. For 90-day mail order, reimbursement for prescription drug co-payments charges shall not exceed \$35 per prescription drug (RX).

* This plan is the prescription drug coverage for the HMSA PPO medical options and is administered by CVS Caremark.

**Member is responsible for 100% of all ineligible charges.

PPO and HMO Prescription Drug Plans – HSTA VB

COVERAGE	PPO Prescription Drug Plan Caremark		HMO Prescription Drug Plan	Supplemental Plan
			Kaiser	HMSA
	Participating Pharmacy*	Non-Participating Pharmacy*		
RETAIL PRESCRIPTION PROGRAM (30 day supply)	Copayment	Copayment plus charges	Copayment	Plan pays up to
Generic and Insulin	\$5 (30 days) \$10 (31-60 days) \$15 (61-90 days)	\$5 + 30% of eligible charges	\$10	\$10
Brand Name	\$15 (30 days) \$30 (31-60 days) \$45 (61-90 days)	\$15 + 30% of eligible charges	\$10	\$25
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	Caremark	Vendor other than Caremark	Kaiser	HMSA
Generic and Insulin	\$9 copayment	Not a Benefit	Generic: \$20 Insulin: Not Available through Mail Order	\$27
Preferred Brand Name	\$27 copayment	Not a Benefit	\$20	\$27

*Member is responsible for 100% of all ineligible charges.

Additional Information for CVS Caremark Prescription Drug Plans

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent or Preferred Brand medication without compromising care as these medications have the same efficacy and are priced lower than Non-Preferred Brand name medications.

Web Service

Members can register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready. If you are not currently a member, please visit our website at www2.caremark.com/eutf for plan information.

Customer Care

For assistance with questions about your plan, finding a participating pharmacy, ordering a new ID card, refilling your mail order, etc. you may call CVS Caremark toll-free 1-855-801-8263 to speak with an on-island representative.

Coordination of Benefits

Some participants may be enrolled in additional prescription coverage outside of their State of Hawaii benefits. If this applies to you, please contact CVS Caremark Customer Care at 1-855-801-8263 to advise if your EUTF plan is secondary. When you go to the pharmacy, let them know that your EUTF plan is secondary and they will be able to coordinate benefits for you at Point of Sale. You also have the option to send in a paper claim form for reimbursement. Below is a list of the required documentation to submit a paper claim for reimbursement. Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF plan parameters and guidelines will still apply and may conflict with your other benefits in some cases.

Required Documentation for Paper Claims:

- Pharmacy receipt including:
 - Patient's name
 - Date of fill
 - Prescription number
 - Name of medication
 - Metric quantity
 - Day supply
 - Pharmacy name & address or pharmacy NABP number
- Completely filled out paper claim form with patient signature

All paper claim reimbursement requests should be mailed to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Utilization Management Programs

In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design. The drug benefit includes the addition of the following three (3) clinical guidelines:

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the **CVS Caremark** National Pharmacy and Therapeutics (P&T) Committee.
2. **Generic Step Therapy Program (GSTP)** - targets single-source, non-preferred brand medications by requiring that a cost-effective generic alternative be used first before the

brand medication. When a prescription for a targeted single-source brand is presented to the pharmacy, the system will check for previous use of an appropriate generic. If the plan participant's claim history shows that a 30-day supply of an appropriate generic was dispensed within a predetermined timeframe (180 or 365 days depending on drug class), the plan will cover the single-source brand. However, if there is no evidence of prior use of an appropriate generic as identified by the plan participant's claim history, the claim will reject and the plan participant must obtain a new prescription for an appropriate generic or select preferred brand, pay out-of-pocket for the non-covered brand, or contact the physician to request a Prior Authorization (PA). If the PA option is requested, the physician must contact the dedicated GSTP PA team at 1-877-418-4131 and provide clinical evidence if a lower-cost alternative is not appropriate.

3. **Prior Authorization** – Authorization process to ensure medical necessity of targeted drugs/classes before they are covered by the plan.

Specialty Drug Program

The EUTF coverage and management of specialty drugs is provided by CVS Caremark Specialty pharmacy. EUTF plan participants are required to obtain specialty medications through a CVS Caremark Specialty pharmacy if they are received in an outpatient office visit or a home setting.

The CVS Caremark Specialty Drug Program uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. If you have questions about your prescription drug benefits, call CVS Caremark at 1-855-801-8263. Representatives are available 24-hours a day to assist with your questions. You can also visit their website at www.caremark.com for additional information about CVS Caremark.

The following programs apply to the EUTF CVS Caremark pharmacy coverage only and not to the HSTA VB pharmacy plans.

Dispensed as Written (DAW 1&2) Program

The Dispensed as Written Program requires participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic co-payment will apply. However, if a participant or their physician chooses to use a brand medication rather than the generic equivalent, then the co-payment becomes the standard generic co-payment plus the difference in the cost of the generic and brand medication.

Mandatory Mail Order Program for Maintenance Medications

Maintenance medications are those prescriptions taken for an extended period of time to treat such chronic conditions as high blood pressure, diabetes, heart disease or high cholesterol. The Maintenance Mail Order Program requires participants obtain these medications through the mail service pharmacy. Mail order provides up to a 90-day supply of medication at one low co-payment. Participants are allowed three (3) 30-day fills at a retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is right. The mail order benefit provides cost savings through lower co-payments and the convenience of home delivery. In addition, plan participants in the EUTF & HMO CVS Caremark plans can fill maintenance medications of up to a 90-day supply at any Longs pharmacy at the lower mail order copay.

Medications requiring refrigeration such as insulin are not subject to the Mandatory Mail Order Program. Participants using drugs needing refrigeration have the option of obtaining those drugs through a local pharmacy or through this program.

The following program applies to the HSTA VB pharmacy plans not to the EUTF CVS Caremark pharmacy coverage.

Dispensed as Written (DAW 2) Program

The Dispensed as Written Program requires participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic co-payment will apply. However, if a participant chooses to use a brand medication rather than the generic equivalent, then the co-payment becomes the standard generic co-payment plus the difference in the cost of the generic and brand medication.

Dental Plan Benefits (Hawaii Dental Services (HDS))– EUTF and HSTA VB

Your Plan provides:

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	\$2,000
DEDUCTIBLE per plan year (July 1 – June 30) (does not apply to benefits covered at 100%)	\$50/person
DIAGNOSTIC	
Examinations - twice per calendar year	100%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	100%
Other X-rays (full mouth X-rays limited to once every 5 years)	100%
PREVENTIVE	
Cleanings – twice per calendar year	100%
<ul style="list-style-type: none"> Diabetic Patients – four Cleanings or *Periodontal Maintenance Expectant Mothers – three Cleanings or *Periodontal Maintenance 	
*Periodontal Maintenance benefit level	*80%
Fluoride (once per calendar year through age 19)	
<ul style="list-style-type: none"> Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist. 	100%
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	100%
RESTORATIVE	
Amalgam (silver-colored) fillings	80%
Composite (white-colored) fillings – limited to the anterior (front) teeth	80%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	80%
Pulpal therapy	
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	80%
Periodontal scaling and root planing – once every two years	
Gingivectomy, flap curettage and osseous surgery – once every three years	
Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	60%
Fixed bridges (once every 5 years; ages 16 and older)	
Dentures (complete and partial – once every 5 years; ages 16 and older)	
Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth	
ORAL SURGERY	80%
ADJUNCTIVE GENERAL SERVICES	80%
Palliative treatment (for relief of pain but not to cure)	100%
ORTHODONTICS	50%
Maximum amount payable by HDS for an eligible patient shall be \$1,000 lifetime per case paid in 8 quarterly payments of \$125.	
Orthodontic services are not covered:	
*If services were started prior to the date the patient became eligible under this employer's plan.	
*If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.	
*If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	

Shaded areas indicate coverage after a Wait Period of 12 months of continuous enrollment in the plan.

Dental Plan Benefits (Hawaii Dental Services (HDS)) – HSTA VB Supplemental Plan

Your Plan provides:

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	\$750
DIAGNOSTIC	
Examinations - twice per calendar year	50%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	50%
Other X-rays (full mouth X-rays limited to once every 5 years)	50%
PREVENTIVE	
Cleanings – twice per calendar year	50%
• Diabetic Patients – four cleanings or *periodontal maintenance	50%
• Expectant Mothers – three cleanings or *periodontal maintenance	
*Periodontal maintenance benefit level	*45%
Fluoride (once per calendar year through age 19)	50%
• Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist.	
Space maintainers (through age 17)	50%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	50%
RESTORATIVE	
Amalgam (silver-colored) fillings	45%
Composite (white-colored) fillings – limited to the anterior (front) teeth	45%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	45%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	45%
Pulpal therapy	
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	45%
Periodontal scaling and root planing – once every two years	
Gingivectomy, flap curettage and osseous surgery – once every three years	
Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	
Fixed bridges (once every 5 years; ages 16 and older)	45%
Dentures (complete and partial – once every 5 years; ages 16 and older)	45%
Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth	50%
ORAL SURGERY	50%
ADJUNCTIVE GENERAL SERVICES	45%
Palliative treatment (for relief of pain but not to cure)	50%
ORTHODONTICS	100%
Maximum amount payable by HDS for an eligible patient shall be \$750 lifetime per case paid in eight quarterly payments of \$93.75.	
Orthodontic services are not covered:	
*If services were started prior to the date the patient became eligible under this employer's plan.	
*If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.	
*If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	

The HDS public website at www.deltadentalhi.org includes a section exclusively for EUTF members. In this section, you will find valuable information on your HDS dental plan including your dental benefits and plan brochure.

Sign up for an online account today to check on your eligibility for services, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, rate your dentist, and receive paperless benefit statements from the convenience of your home computer or smartphone.

To sign up for an online account and paperless benefit statements:

- 1) To go www.deltadentalhi.org
- 2) Click on "New User?" at the top left of the screen.
- 3) Complete the "Member Registration" form.
- 4) Select "Yes" to "Request electronic Explanation of Benefits."
- 5) Click on "Register User" button.

Vision Plan Benefits (Vision Service Plan (VSP)) – EUTF and HSTA VB

Your coverage from a VSP Doctor:

Exam covered in full every plan year, after \$10 Copay

Prescription Glasses

Lenses covered in full every plan year, after \$25 Copay

- Single vision, lined bifocal and lined trifocal lenses
- Polycarbonate lenses for dependent children up to age 18

Frame every other plan year

- \$120 allowance, plus 20% off any out-of-pocket costs
- OR \$65 allowance at COSTCO (no additional discounts)

~Instead of Glasses~

Contact Lenses every plan year

- \$120 allowance (applies to cost of contacts and fitting & evaluation)

Extra Discounts and Savings

Glasses & Sunglasses

- Average 35-40% savings on all non-covered lens options (such as tints, progressive lenses, anti-scratch coatings, etc.) UV coating is covered at no extra charge.
- 30% off additional glasses & sunglasses, including lens options, from the same VSP doctor on the same day as your Exam. OR get 20% off from any VSP doctor within 12 months of your last Exam.

Contact Lenses

15% off cost of contact lens exam (fitting & evaluation)

VSP has partnered with leading contact lens manufacturers to provide VSP members exclusive offers. Check out www.vsp.com for details.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

You get the best value from your VSP benefit when you visit a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 12 months to submit a claim to VSP for partial reimbursement, less copays according to the following schedule:

Out-of-Network Reimbursement Amounts

Exam Up to \$45.00

Single Vision Lenses Up to \$45.00

Lined Bifocal Lenses Up to \$65.00

Lined Trifocal Lenses Up to \$85.00

Frame Up to \$47.00

Contacts Up to \$105.00

Before seeing an out-of-network provider, call VSP at 1-800-877-7195, or go on-line at www.vsp.com to search for a VSP doctor near you!

Life Insurance (Royal State National (RSN))

Your life insurance benefit will be \$38,361, for active participants.

- Your benefit will reduce once you reach age 65 and continue to reduce as follows:
 - \$24,935 for participants age 65 through 69
 - \$17,262 for participants age 70 through 74
 - \$11,508 for participants age 75 through 79
 - \$7,672 for participants age 80 and over

In addition, your life insurance includes the following added benefits:

- Conversion – If your life insurance ceases because of termination of employment or is reduced due to age or retirement, you may convert to an individual whole life insurance policy. You do not need to provide evidence of good health.
- Portability - this provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements.
- Accelerated Benefit – allows you to receive an early payment of a portion of your life insurance if you have a Qualified Medical Condition and meet certain requirements.
- Repatriation of remains benefit – this benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home.

Contact Royal State National at (808) 539-1621 or toll free at 1-888-942-2447 if you would like to change your beneficiary. You may download the beneficiary designation form from the Royal State National website at: www.royalstate.com.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- ▶ Providing current and accurate personal information as prescribed in this booklet
- ▶ Paying the employee's premium contributions in the amount or amounts provided by statute, or an applicable bargaining unit agreement;
- ▶ Paying the employee's premium contributions at the times and in the manner designated by the board; and
- ▶ Complying with the EUTF's rules.

Employer Responsibilities

Any public employer whose current or former employees participate in EUTF benefit plans is responsible for:

- ▶ Providing information as requested by the EUTF under section 87A-24(9) of the Hawaii Revised Statutes;
- ▶ Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- ▶ Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries;
- ▶ Complying with the EUTF's rules;
- ▶ Notifying EUTF immediately following termination and Bargaining Unit changes.

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the EUTF. The notice shall be sent within thirty days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due.

Other Actions

The EUTF shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the EUTF.

Future Retirees

Medicare Part B Enrollment for Medicare Eligible Employees (65+) Considering Retirement

The Hawaii Revised Statutes 87A-23(4) requires that State and County retirees and their dependents who are enrolled in EUTF retiree benefit plans must enroll in Medicare Part B. Active employees considering retirement who are eligible for Medicare should enroll in Medicare Part B in order to participate in any EUTF retiree benefit plan. At the time you complete your retiree (EC-2) enrollment form, provide a copy of your Medicare Part B card as proof of enrollment. If no proof of enrollment is submitted within 60 days, your enrollment into the EUTF Retiree Benefit Plans will be cancelled back to your date of retirement.

Employees should begin the Medicare Part B enrollment process at least 45 days prior to retirement, by contacting the Social Security Administration at 1-800-772-1213. For more information regarding Medicare, employees should contact Medicare directly at 1-800-633-4227.

If you or your dependent are currently Medicare eligible and you are not considering retirement, EUTF does not require you or your dependent to enroll in Medicare.

In addition, if you are thinking about retirement during the upcoming plan year, you should consider the policies implemented by the providers regarding annual maximums and annual limits for medical, dental, vision and prescription drug benefits. Benefits that are paid under the Active employee plans are counted against the maximums and limitations of the Retiree Plans if they occur within the same calendar year.

Dental example:

On January 1, 2013, John was an active employee and incurred \$500 in dental services. He retires on July 1, 2013 and proceeds to have additional dental services totaling \$1,000. In total, John has incurred \$1,500 in dental services for 2013. Although as an active employee John's dental benefit maximum was \$2,000 per plan year, as a retiree his dental benefit maximum is now only \$1,000 per calendar year. Therefore, because he used \$500 in dental benefits as an active employee and only had \$500 remaining as a retiree, John owes the dentist \$500 because his services were all incurred within the same calendar year.

Medical Out-of-Pocket maximum example:

On January 1, 2013, Jane was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. By July 1, 2013 she had met her \$2,000 calendar year out of pocket limit under that plan. She incurs additional medical expenses in August 2013, which are paid at 100% since her out of pocket limit was satisfied. She retires on September 1, 2013 and enrolls in the EUTF HMSA Retiree PPO plan. She proceeds to have additional medical services totaling \$1,000 before the end of 2013. As an active employee, Jane's out-of-pocket limit was \$2,000 per calendar year, but as a retiree her out-of-pocket limit is now \$2,500 per calendar year. Therefore instead of 100% coverage for the additional \$1,000 of medical expenses, she had to pay 10% of those expenses because she needed an additional \$500 of out of pocket expenses to meet the out of pocket limit under her retiree plan.

Medical Deductible example:

On January 1, 2013, Jill was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. She met her individual non-network deductible of \$100 in May 2013. She retires on June 1, 2013 and enrolls in the EUTF HMSA Retiree PPO plan. The \$100 deductible she met under the Active plan will apply to the Retiree plan since it is within the same calendar year. She will not be subject to an additional deductible under the Retiree plan.

Attention: Medicare Eligible Members and/or Dependents Enrolling in EUTF

Attention: Medicare Eligible Members

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. The EUTF sponsored prescription drug plan, except for the supplemental plans, offers benefits that are as good, or better, than the standard Medicare Part D plan coverage. A summary of your Notice of Creditable Coverage appears below.

If you are enrolled in the supplemental medical plan, your prescription drug coverage is considered to be non-creditable when compared to the standard Medicare Part D plan. A summary of your Notice of Non-Creditable Coverage appears below.

Prescription Drug Benefits

The **Medicare Prescription Drug Program** (Medicare Part D) was established to provide prescription drug coverage for eligible Medicare individuals. Your employer is required to inform you whether or not your prescription drug plan is creditable or non-creditable.

Notice of Creditable Coverage (available at EUTF website at eutf.hawaii.gov)

Since you are or may become eligible for Medicare during the next year, the EUTF is required by law to notify you regarding your rights to the Medicare Part D prescription drug coverage. If you are enrolled in an EUTF plan other than a supplemental plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits. Although you have the right to join a Medicare Part D prescription drug plan, doing so may disrupt your regular medical coverage, and you do not have to do so at this time. Medicare will not penalize you if you decide to enroll in a Medicare Part D plan in the future, because the prescription drug coverage you now have through the EUTF is creditable coverage.

If you decide to join a Medicare Part D plan, you should compare the different drugs that are available under your current plan with EUTF and the alternative plans. Not all Medicare Part D plans cover the same drugs, nor provide the coverage at the same cost.

Notice of Non-Creditable Coverage (available at EUTF website at eutf.hawaii.gov)

If you are enrolled in a supplemental medical plan, the EUTF has determined that your prescription drug benefits are not as good as or better than the standard Medicare Part D drug benefits. As a rule, you are enrolled in the supplemental medical plan because you are also enrolled in another prescription drug plan and you should have received a Notice of Creditable Coverage from that other plan. If your other plan's prescription drug benefits are also non-creditable coverage, you should consider enrolling in Medicare Part D when you first become eligible to do so. If you don't enroll in Part D when you are first eligible to do so, you may have to pay a penalty (a higher premium) for your Part D coverage when you later do enroll, and you may have to pay that penalty for as long as you are covered under Part D.

It is important to note that if you enroll in a Medicare Part D plan, the EUTF will not reimburse you for the premiums.

INSTRUCTIONS FOR COMPLETING FORM EC-1

Please print or type clearly. If the EC-1 form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the EC-1 form to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing.

SECTION 1 - EMPLOYEE DATA

1. Enter your full legal name as recorded on your Social Security card.
2. Enter your contact information.
3. Enter your address information. If your mailing address differs from your residential address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire box if:
 - A) You are a new employee; and enter the effective date you were hired, or
 - B) Your employment status is changing from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
5. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
6. Mark the Termination box if you are terminating your employment; and enter your close of business date.
7. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number.
8. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a birth date.
9. Mark the Mid-Year Qualifying Event box if you have made any changes during the year; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Transfer In, Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
10. If you are Married, or in a Civil Union, or in a Domestic Partnership please be sure to check the appropriate boxes and include the date you were Married, or entered into a Civil Union, or Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health.
11. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her Social Security Number. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Civil Union Partner/Domestic Partner are employee beneficiaries, only one of you may enroll in an EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in an EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND DEDUCTION START SELECTION

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Civil Union, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.
3. For the following events: Marriage, Civil Union, Domestic Partner and New Eligible Student; the event date is when your Personnel Office or DPO receives proper notification. Your effective date will be based on your event date and the box you selected.
4. DPO to complete Effective Date of Coverage and Premium Contribution begins date.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in. If you do not make a selection, you will be considered as cancelling/waiving coverage.

1. Carefully review each selection that you make. You can choose ONE medical, ONE dental, and ONE vision plan. Your choice of the prescription drug plan will depend on the medical plan that you select. If you select an HMO, HDHP or Supplemental plan, your medical selection will include a prescription drug plan. If you select a PPO plan, you must select the prescription drug plan if you want drug coverage. If you do not make a selection, you will not have any prescription drug coverage.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you do not make a selection or check the "Cancel/Waive" box, you will be considered as waiving the selection(s). To be eligible for Supplemental medical plan coverage, you must have other medical coverage from another source, not including this employer.
3. The RSN ChiroPlan is included with all medical plans except for the EUTF High Deductible Health Plan (HDHP).
4. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the "Cancel/Waive" box for each plan that you choose not to select.
5. Life insurance is provided by this employer for the employee only.
6. FOR STATE EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at <http://dhrd.hawaii.gov>. Please inquire with your DPO or DHRD on completing a PCP-2 form.
-Mark one of the following boxes: ☐ Enroll, ☐ Change Amount, ☐ Cancel PCP, or ☐ Do NOT Enroll.
FOR COUNTY EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information.

INSTRUCTIONS FOR COMPLETING FORM EC-1 (continued)

Write your name in the top right corner.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number. Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the birth date blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1.
2. Use the following Relationship codes:
SP = Spouse CH = Child SC = Step Child
CU = Civil Union Partner ✓ CUCH = Civil Union Partner Child ✓ GC = Guardianship or Foster Child ✓✓
DP = Domestic Partner ✓✓✓ DPCH = Domestic Partner Child ✓✓✓ DC = Disabled Child ✓✓✓✓
3. For Relationship codes with ✓ or ✓✓ or ✓✓✓ or ✓✓✓✓, please see item #8 and #9 below for other required forms.
4. Gender – Write/type either M or F.
5. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.
7. Civil Union Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.
8. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.
9. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through your employer within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at anytime outside of Open Enrollment, provided all required documents have been received by your employing office within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
10. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):
 - ✓ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable)
 - ✓ EUTF Declaration of Domestic Partnership
 - ✓ Affidavit of "Dependency" for Tax Purposes
 - ✓ DHRD Civil Union Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
 - ✓ DHRD PCP 2 form (For State Employees Only)
 - ✓✓ Legal documents for guardianship or foster child
 - ✓✓✓ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
 - ✓✓✓ Affidavit of "Dependency" for Tax Purposes
 - ✓✓✓ DHRD Domestic Partnership Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
 - ✓✓✓ DHRD PCP 2 form (For State Employees Only)
 - ✓✓✓✓ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s) (private / Federal), please complete this section. If you selected a supplemental medical plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).

Note: To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group plan (private / Federal).

SECTION 6 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

You must submit the EC-1 through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF.

EMPLOYER VALIDATION [for EMPLOYER USE ONLY]

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education, 010022 for University of Hawaii, 010053 for Budget and Finance, etc.
2. Department and Division/School - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1 was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1, not the date the DPO / employer designee received it.
5. Please provide contact phone and fax numbers.
6. DPO / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1 was signed by the DPO / employer designee.

INSTRUCTIONS FOR COMPLETING FORM EC-1H

Please print or type clearly. If the EC-1H form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the EC-1H form to the Department of Education – Health Benefits and Awards Unit (DOE – HBAU) or Hawaii Public Charter Schools (HIPCS) for verification, signature, and routing.

SECTION 1 - EMPLOYEE DATA

1. Enter your full legal name as recorded on your Social Security card.
2. Enter your contact information.
3. Enter your address information. If your mailing address differs from your residential address, you need to enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire box if:
 - A) You are a new employee; and enter the effective date you were hired, or
 - B) Your employment status is changing from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
5. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
6. Mark the Termination box if you are terminating your employment; and enter your close of business date.
7. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number.
8. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a birth date.
9. Mark the Mid-Year Qualifying Event box if you have made any changes during the year; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Transfer In, Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
10. If you are Married, or in a Civil Union, or in a Domestic Partnership please be sure to check the appropriate boxes and include the date you were Married, or entered in a Civil Union, or entered in a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health.
11. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her Social Security Number. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Civil Union Partner/Domestic Partner are employee beneficiaries, only one of you may enroll in an EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in an EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND DEDUCTION START SELECTION

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Civil Union, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.
3. For the following events: Marriage, Civil Union, Domestic Partner and New Eligible Student; the event date is when DOE – HBAU / HIPCS receives proper notification. Your effective date will be based on your event date and the box you selected.
4. DOE – HBAU / HIPCS to complete Effective Date of Coverage and Premium Contribution begins date.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in. If you do not make a selection, you will be considered as cancelling/waiving coverage.

1. Carefully review each selection that you make. You can choose ONE medical, ONE dental, and ONE vision plan. Your prescription drug plan will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you do not make a selection or check the "Cancel/Waive" box, you will be considered as waiving the selection(s). To be eligible for Supplemental medical plan coverage, you must have other medical coverage from another source, not including this employer.
3. The RSN ChiroPlan is included with all medical plans.
4. If you have other health plan coverage and do not want to participate in EUTF's HSTA VB type plans, mark the "Cancel/Waive" box for each plan that you choose not to select.
5. Life insurance is provided by this employer for the employee only.
6. FOR STATE EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at <http://dhrd.hawaii.gov>. Please inquire with DOE – HBAU / HIPCS or DHRD on completing a PCP-2 form.

-Mark one of the following boxes: ☐ Enroll, ☐ Change Amount, ☐ Cancel PCP, or ☐ Do NOT Enroll.

INSTRUCTIONS FOR COMPLETING FORM EC-1H (continued)

Write your name in the top right corner.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number. Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the birth date blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1H.
2. Use the following Relationship codes:
SP = Spouse CH = Child SC = Step Child
CU = Civil Union Partner ✓ CUCH = Civil Union Partner Child ✓ GC = Guardianship or Foster Child ✓✓
DP = Domestic Partner ✓✓✓ DPCH = Domestic Partner Child ✓✓✓ DC = Disabled Child ✓✓✓✓
3. For Relationship codes with ✓ or ✓✓ or ✓✓✓ or ✓✓✓✓, please see item #8 and #9 below for other required forms.
4. Gender – Write/type either M or F.
5. Plan Selections. **YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED.** If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.
7. Civil Union Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.
8. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.
9. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through DOE - HBAU / HIPCS within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at anytime outside of Open Enrollment, provided all required documents have been received by the DOE - HBAU / HIPCS within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
10. Other EUTF and/or DRHD forms to include with EC-1H (if applicable):
 - ✓ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable)
 - ✓ EUTF Declaration of Domestic Partnership
 - ✓ Affidavit of "Dependency" for Tax Purposes
 - ✓ DHRD Civil Union Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
 - ✓ DHRD PCP 2 form (For State Employees Only)
 - ✓✓ Legal documents for guardianship or foster child
 - ✓✓✓ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
 - ✓✓✓ Affidavit of "Dependency" for Tax Purposes
 - ✓✓✓ DHRD Domestic Partnership Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
 - ✓✓✓ DHRD PCP 2 form (For State Employees Only)
 - ✓✓✓✓ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s) (private / Federal), please complete this section. If you selected a supplemental medical plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).

Note: To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group plan (private / Federal).

SECTION 6 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

You must submit the EC-1H through the DOE – HBAU / HIPCS. The DOE – HBAU / HIPCS confirms that you are a current employee and are eligible for health benefits through the EUTF.

EMPLOYER VALIDATION [for EMPLOYER USE ONLY]

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education.
2. Department and Division/School - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1H was received from the employee. The date recorded should be the date that the **DOE - HBAU / HIPCS** received it.
5. Please provide contact phone and fax numbers.
6. DOE - HBAU / HIPCS designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1H was signed by the DOE - HBAU / HIPCS designee.

EC-1

Rev. Apr 2013

Hawaii Employer-Union Health Benefits Trust Fund

EC-1: Enrollment Form for Active Employees

PLEASE SUBMIT THIS
FORM EC-1 TO YOUR
PERSONNEL OFFICE

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social Security numbers are required to process new hires and dependent enrollments. **

Name (Last, First, Middle)

☐ New Hire
Date of Hire (MM/DD/YYYY)☐ Mid-Year Qualifying Event (describe)

Home Phone ()

Mobile Phone ()

Work Phone ()

Email

☐ Open Enrollment☐ Termination
Date of Termination (MM/DD/YYYY)

Event Date: / /

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)Residence Address (☐ Check this box if your address has changed)

Street

Line 2

City State Zip Code

Employee's Social Security Number (SSN)
or EUTF ID Number☐ Civil Union
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)

Mailing Address (if different from above)

Street

Line 2

City State Zip Code

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)
(☐ Check this box if status change)Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN:

Section 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates.

If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section

Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section

- ☐
- Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used)
-
- ☐
- Coverage and premium contributions start 1st day of the first pay period following event
-
- ☐
- Coverage and premium contributions start 1st day of the second pay period following event

Completed by DPO → Effective Date of Coverage: Premium Contribution begins:

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.

Medical Plan

Type

Carrier Selection

Choose only one box in each plan selection

Cancel/Waive Self 2-Party Family

PPO

PPO-90/10 HMSA Medical,
Chiro☐☐☐☐PPO-80/20 HMSA Medical,
Chiro☐☐☐☐PPO-75/25 HMSA Medical,
Chiro☐☐☐☐

Prescription Drug

Prescription Drug
(Not a valid selection w/ supplemental plans)☐☐☐☐

HMO

HMO-HMSA
Prescription Drug Coverage, Chiro☐☐☐☐HMO-Kaiser Standard
(Includes Drug Coverage), Chiro☐☐☐☐HMO-Kaiser Comprehensive
(Includes Drug Coverage), Chiro☐☐☐☐

Supplemental

Supplemental-HMSA
(Includes Supplemental Drug Coverage), Chiro *☐☐☐☐Supplemental-Royal State National Insurance Company
(Includes Supplemental Drug Coverage), Chiro *☐☐☐☐*** To be eligible for coverage under any Supplemental Health Benefit Plan,
you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

Other Plans

Cancel/Waive Self 2-Party Family

Dental

Hawaii Dental Service

☐☐☐☐

Vision

Vision Service Plan

☐☐☐☐

Life

Royal State National

☐☐For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll ☐ Change Amount ☐ Cancel PCP ☐ Do NOT Enroll

For COUNTY Employees ONLY: Premium Conversion Plan – Please contact your DPO for more information on available options.

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CP=Civil Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CPCH=Civil Partner's Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information received/issued by SSA.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.

Dependent Certification – See Section regarding Dependent Certification on “Instructions for Completing Form EC-1” for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ (initials)

Domestic Partner Certification – See Section regarding Domestic Partner Certification on “Instructions for Completing Form EC-1” for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ (initials)

SECTION 5: OTHER INSURANCE INFORMATION

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
				Self	2-Party	Family
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the “waive” box, it will be considered a “waive.” I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1 Received in Employing Office	/ /	DPO Phone Number	DPO Fax Number
DPO (or employer designee's) Printed Name DPO (or employer designee's) Signature:			Date of DPO (or employer designee's) Signature / /
Remarks:			

EC-1H: Enrollment Form for HSTA VB Active BU 05/45 Employees

PLEASE SUBMIT THIS
FORM EC-1H TO THE
DOE-EBU / HIPCS FOR
ROUTING

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social Security numbers are required to process new hires and dependent enrollments. **

Name (Last, First, Middle)

☐ New Hire
Date of Hire (MM/DD/YYYY)☐ Mid-Year Qualifying Event (describe)

Home Phone (____)

Mobile Phone (____)

Work Phone (____)

Email _____

☐ Open Enrollment☐ Termination
Date of Termination (MM/DD/YYYY)Marital Status ☐ Married ☐ Single

Marriage Date: (MM/DD/YYYY)

☐ Check this box if status changeResidence Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Employee's Social Security Number (SSN)
or EUTF ID Number☐ Civil Union

Civil Union Date: (MM/DD/YYYY)

☐ Check this box if status change

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

Domestic Partner (DP Status)

☐ IRS Qualified ☐ Not Qualified

DP Date: (MM/DD/YYYY)

☐ Check this box if status changeSpecial Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN:

Section 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates.

If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section

Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section

- ☐
- Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used)
-
- ☐
- Coverage and premium contributions start 1st day of the first pay period following event
-
- ☐
- Coverage and premium contributions start 1st day of the second pay period following event

Completed by DOE - EBU / HIPCS → Effective Date of Coverage: _____ Premium Contribution begins: _____

SECTION 3: PLAN SELECTION

Make your selection by checking the all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.

Medical Plan

Type

Carrier Selection

Choose only one box in each plan selection

Cancel/Waive

Self

2-Party

Family

PPO

PPO-80/20 HMSA Medical and Drug,
Vision, Chiro☐☐☐☐PPO-90/10 HMSA Medical and Drug,
Vision, Chiro☐☐☐☐

HMO

HMO-Kaiser Comprehensive Medical and Drug,
Vision, Chiro☐☐☐☐

Supplemental

Supplemental-HMSA Medical, Drug and Vision,
Chiro *☐☐☐☐

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

Other Plans

Cancel/Waive

Self

2-Party

Family

Dental

Hawaii Dental Service

☐☐☐☐

Supplemental Hawaii Dental Service *

☐☐☐☐

Vision

Vision Service Plan

☐☐☐☐

Life

Royal State National

☐☐For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll☐ Change Amount☐ Cancel PCP☐ Do NOT Enroll

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CP=Civil Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CPCH=Civil Partner's Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information received/issued by SSA.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.

Dependent Certification – See Section regarding Dependent Certification on “Instructions for Completing Form EC-1H” for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans.

_____ (initials)

Domestic Partner Certification – See Section regarding Domestic Partner Certification on “Instructions for Completing Form EC-1H” for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions.

_____ (initials)

SECTION 5: OTHER INSURANCE INFORMATION

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
				Self	2-Party	Family
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the “waive” box, it will be considered a “waive.” I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1H Received in DOE-EBU / HIPCS Office / /		DOE-EBU / HIPCS Phone Number	DOE-EBU / HIPCS Fax Number
DOE-EBU / HIPCS (or employer designee's) Printed Name DOE-EBU / HIPCS (or employer designee's) Signature:		Date of DOE-EBU / HIPCS (or employer designee's) Signature / /	
Remarks:			

**FORMS SUBMITTED
TO YOUR EMPLOYER'S
OPEN ENROLLMENT
DESIGNEE
AFTER FRIDAY,
MAY 10, 2013
WILL BE REJECTED**

For More Information

For Questions about...	Please Contact...
Eligibility & EUTF Information	eutf@hawaii.gov EUTF Customer Service Call Center 808-586-7390 or Toll Free: 1-800-295-0089 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST)
Hawaii Medical Service Association (HMSA)	www.hmsa.com 808-948-6499 or Toll Free: 1-800-776-4672 (Monday through Friday, 7:00 a.m. – 7:00 p.m. HST) Hilo: 808-935-5441, Kailua-Kona: 808-329-5291 Kahului: 808-871-6295, Lihue: 808-245-3393 (Monday through Friday, 8:00 a.m. – 4:00 p.m. HST)
Kaiser Permanente (Kaiser)	www.kp.org/hi/eutf 808-432-5955 (Oahu) or Toll Free: 1-800-966-5955 (Neighbor Islands) (Monday through Friday, 8:00 a.m. – 5:00 p.m. HST Saturdays 8:00 a.m. – 12:00 p.m. HST)
CVS Caremark (CVS)	www.caremark.com/ www2.caremark.com/eutf/ 1-855-801-8263 (24 hours a day, 7 days a week)
Royal State National (RSN)	Chiropractic Benefit 808-621-4774 or Toll Free: 1-800-414-8845 www.chiroplanhawaii.com (Monday through Friday, 9:00 a.m. – 5:00 p.m. HST) Supplemental Medical Plan 808-539-1621 or Toll Free: 1-888-942-2447 www.royalstate.com (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST) Life Insurance 808-539-1621 or Toll Free: 1-888-942-2447 www.royalstate.com (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST)
Vision Service Plan (VSP)	www.vsp.com 808-532-1600 or Toll Free: 1-800-522-5162 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) Toll Free for Mainland: 1-800-877-7195 (Monday through Friday, 5:00 a.m. – 7:00 p.m. PST Saturdays 6:00 a.m. – 2:30 p.m. PST)
Hawaii Dental Service (HDS)	www.deltadentalhi.org 808-529-9310 or Toll Free: 1-866-702-3883 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST)

Plan information can also be found online via the “Links to Carrier Web Sites” located on the EUTF website at eutf.hawaii.gov